IMMUNIZATION SCREENING QUESTIONNAIRE

(See DD Form 2005 for Privacy Act Statement)

Patient's name *(Last, First, MI)*	Rank	Relationship to Sponsor	Date

Sponsor's name *(Last, First, MI) (If same as patient's, enter "Same")*	Sponsor's rank	Sponsor's SSN and patient's prefix	Sponsor's status
			☐ Active duty ☐ Retired

Please answer the following questions. This will help us to determine which vaccines may be given to you, or to your child, today. If a question is unclear to you, please ask one of our staff members for an explanation.

For All Patients	**Yes**	**No**	**Don't Know**
1. Are you sick today? *(For example, do you have a high fever, chills, etc?)*			
2. Have you ever passed out after a shot?			
3. Have you ever had a serious reaction to any vaccines in the past?			
4. Do you have (or do you **think** you have) allergies to any of the following? ☐ Gelatin ☐ Eggs ☐ Thimersol ☐ Neomycin ☐ Latex or rubber ☐ Medications			
5. Do you, any person who lives with you, or any person you take care of have cancer, leukemia, AIDS, or any other immune system problem?			
6. Do you, any person who lives with you, or any person you take care of take cortisone, predisone, other steriods, anticancer drugs or x-ray treatments in the past 3 months?			
7. Have you received a transfusion of blood or plasma, or been given a medicine called immune globulin in the past year?			
8. Do you take a blood thinner like coumadin or do you have a bleeding problem?			
For Female Patients Only	**Yes**	**No**	**Don't Know**
9. Are you or do you have a reason to believe that you are pregnant? What was the date of your last menstrual period: _____			
	Yes	**No**	**N/A**
10. Are you receiving a <u>live viral vaccine</u> (i.e., measles, mumps, rubella, chickenpox/varicella, or yellow fever)? If so, you are warned against becoming pregnant for **3 months** after getting the vaccine. Please initial here to signify you understand the above statement: _____			

For All Patients	**Yes**	**No**	**I was given information for the following vaccines**	**Date**
11. Have you been offered written information about the vaccine(s) you are getting and have all your questions been answered?				

Signature	Date

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